

Pennine Care NHS Foundation Trust

Community-based mental health services for older people

Quality Report

225 Old Street
Ashton Under Lyne
Lancashire
OL6 7SR A
Tel: 0161 7163877
Website: <https://www.penninecare.nhs.uk/>

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RT2HQ	Trust Headquarters	Stockport older people's community mental health team	SK2 5EQ
RT2HQ	Trust Headquarters	Stockport older people's intensive home treatment team	SK2 5EQ
RT2HQ	Trust Headquarters	Rochdale, Heywood and Middleton older people's community mental health team	OL12 9QB
RT2HQ	Trust Headquarters	Rochdale, Heywood and Middleton older people's intensive home treatment team	OL12 9QB

Summary of findings

RT2HQ	Trust Headquarters	Bury older people's community mental health nursing team	BL9 0JT
RT2HQ	Trust Headquarters	Tameside older people's community mental health team	OL6 9RW
RT2HQ	Trust Headquarters	Tameside older people's intensive home treatment team	OL6 9RW

This report describes our judgement of the quality of care provided within this core service by Pennine Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for older people as good because:

- There were safe lone working arrangements in place when staff visited patients' homes. Staff had reasonable caseloads so staff could keep patients safe. Referral information was coordinated and actioned quickly. Care plans had crisis care plans to inform patients and carers on what to do in crisis. Patients' records contained comprehensive risk assessment. Staff were kept up-to-date with good mandatory training uptake.
- There was effective multidisciplinary working in most teams. Staff completed life story work with patients with dementia to enable them to provide person centred care. There was good interagency working including with voluntary and third sector organisations. Staff took action to ensure that patients' physical health needs were monitored and treated. There were good systems to ensure the Mental Health Act was followed where patients were on a community treatment order. Staff had a good understanding of the Mental Health Act and Mental Capacity Act despite this not being required mandatory training.
- Patients were highly complimentary about the care they received. Records showed support workers going the extra mile to support patients. There was significant service user involvement and community engagement in Stockport, including people with dementia providing peer support and post diagnostic support to people with a recent diagnosis of dementia as well as being involved as partners in staff training.
- Access into the services was coordinated through a single point of entry in each locality. There were no waiting lists to receive an assessment or receive treatment. The teams were meeting the targets expected of them. There were specialist workers within some teams such as an early onset dementia team in Stockport and a specialist vascular dementia worker in

Bury. There were proactive contact with Black and minority ethnic communities to promote the work of the teams, improve referrals and for health promotion. There were low numbers of complaints and these were well managed.

- Staff understood the trust's vision and values. Teams were well-led by committed managers and staff felt respected and supported by managers. Effective managerial operations meetings took place where incidents were discussed, team performance was reviewed and staffing and sickness in teams was considered. There was a commitment to service improvement and extending services to meet the needs of different patient groups.

However:

- There were unsecure records at the offices in Bury which was a shared building with non-trust staff working in the building. The trust took action to address this immediately following the inspection.
- There were issues with informing patients on a community treatment order about the availability of the independent mental health advocacy service and ensuring the legal certificate to provide treatment to a community patient was kept with the medication card.
- Records did not always contain full details of the legal safeguards when decisions were made on behalf of incapacitated patients such as the extent of any lasting or enduring power of attorney decisions and the conditions and Deprivation of Liberty Safeguards authorisations.
- Staff in the Bury team did not always request interpreter involvement for more routine appointments when the patients' first language was not English.
- The trust did not provide any steer around how each team could evidence or develop services in line with the trust's three quality priorities for 2015/16.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as good because:

- There were safe lone working arrangements in place to support staff when visiting patients' homes.
- Patients told us that they felt safe.
- Staff had reasonable caseloads so staff could monitor patients and keep them safe.
- When patients were referred into the service, referral information was coordinated and actioned quickly and prioritised according to information on any risks posed to the patient or others.
- Care plans had crisis care plans to inform patients and carers on what to do if they were in crisis.
- Most patient records contained comprehensive risk assessments.
- Staff were kept up-to-date with good mandatory training uptake.
- Staff were aware of what incidents to report.
- There were systems in place to ensure lessons were learnt from incidents including regular newsletters, intranet updates and discussions in team meetings and supervision.

However:

- There were unlocked records at the offices in Bury which was a shared building with non-trust staff working in the building. The trust took action to address this immediately following the inspection.

Good



Are services effective?

We rated effective as good because:

- There was effective multidisciplinary working in most teams. While there were no integrated psychologists in the Stockport and Rochdale teams and no integrated social workers in the Bury team, patients could still be referred to these services.
- Staff completed life story work with patients with dementia to enable them to provide person centred care which took account of people's lives and interests.
- There was good interagency working including with the voluntary and third sector. For example, the Bury team worked with and alongside workers from the Alzheimer's Society who provided post diagnostic casework support to people with dementia.

Good



Summary of findings

- Care plans showed that staff considered patients' physical health needs and took action to ensure that patients' physical health needs were monitored and treated.
- There were good systems in place to ensure the Mental Health Act was followed where patients were on a community treatment order.
- Staff had a good understanding of the Mental Health Act and Mental Capacity Act despite this not being required mandatory training.

However:

- There were multiple patient recording systems including separate consultant psychiatrist records, paper records and electronic records. This made it difficult to find key documents and the risks of patient information being held across multiple records were not always fully mitigated.
- We found minor issues with informing patients on a community treatment order about the availability of the independent mental health advocacy service. The second opinion appointed doctor certificate for one patient was not kept with the medication card.
- Records did not always contain full details of the legal safeguards when decisions were made on behalf of incapacitated patients such as recording the extent of any lasting or enduring power of attorney decisions, the conditions and the limits on any Deprivation of Liberty Safeguards authorisations that patients were subject to and whether patients had any advance decisions.

Are services caring?

We rated caring as good because:

- Patients were highly complimentary about the care and treatment they received from caring and experienced staff.
- Records showed support workers going the extra mile to support patients.
- There were good results on the friends and family test with patients stating they were happy to recommend people they know to receive treatment from older people's mental health community teams.
- There was significant service user involvement and community engagement including in services in Stockport, people with dementia providing peer support and post diagnostic support to patients with a recent diagnosis of dementia as well as being involved as partners in staff training.

Good



Summary of findings

- In Stockport, service users and staff were working with local leisure facilities to make them 'dementia friendly'.
- Care plans included carer support.
- Information leaflets were provided to people and carers to explain particular information in more detail.

Are services responsive to people's needs?

We rated responsive as good because:

- Access into the services was coordinated through a single point of entry in each locality with staff designated to consider each referral and determine the most appropriate response.
- There were no waiting lists to receive an assessment or receive treatment.
- The teams were meeting the targets expected of them including ensuring all patients were fully assessed within six weeks and all patients receiving a diagnosis within 12 weeks.
- There were specialist workers within some teams to ensure targeted service responses including an early onset dementia team in Stockport and a specialist vascular dementia worker in Bury.
- There was proactive contact with Black and minority ethnic communities to promote the work of the teams, improve referrals and for health promotion. For example the Bury team was reaching out to south Asian and Jewish communities.
- There were low numbers of complaints and these were well managed. People who used services knew how to make a complaint.
- The teams operated a service from 9am to 5pm seven days a week with more limited staff at weekends. Older people in crisis attended the emergency department to be assessed by staff from the rapid assessment, interface and discharge service outside of these hours.

However:

- While interpreters were arranged for significant appointments such as care programme approach reviews when patients first language was not English, staff in the Bury team did not always request interpreter involvement for more routine appointments.

Good



Are services well-led?

We rated well led as good because:

- Staff understood the trust's vision and values.
- Teams were well-led by committed managers.

Good



Summary of findings

- Morale was reported to be good and staff felt respected and supported by managers.
- There were good governance arrangements in place including locality based service managers who supported teams.
- Effective managerial operations meetings took place where incidents were discussed, team performance was reviewed and staffing and sickness in teams was considered.
- There was a commitment to service improvement and extending services to meet the needs of different patient groups, for example the development of the vascular dementia worker, the early onset team and the community rapid assessment, interface and discharge teams.
- Managers contributed to the local dementia strategy in each area.

However:

- The trust did not provide any steer or guidance around how each team could evidence or develop services in line with the trust's three quality priorities for 2015/16.

Summary of findings

Information about the service

Pennine Care NHS Foundation Trust has a number of older people's community mental health teams, which deliver a range of community mental health services across Bury, Rochdale, Oldham, Tameside and Oldham.

Community mental health teams for older adults deliver person centred care and treatment to patients over 65 with both organic and functional illnesses. The teams work in partnership with a range of agencies, to aid and maintain recovery and reduce admissions to hospital. They also support people in nursing or residential care.

Pennine Care NHS Foundation Trust's range of older people's community mental health included:

- Community mental health teams providing care and treatment to older people with mental health needs in the community.
- Memory clinics which assess, diagnose and treat people with dementia.

- Older people's rapid assessment, interface and discharge (RAID) teams. Staff from these teams worked within each neighbouring acute hospitals to provide professional mental health treatment, support and input when patients were receiving treatment on acute medical wards and in the emergency department.
- Older people's home intervention teams which provided crisis input with more intensive support to keep people out of hospital where possible and provide support on discharge from hospital.

People are often seen in their own homes and at outpatient clinics where appropriate.

We have not inspected the community older people's mental health services provided by Pennine Care NHS Foundation Trust before this inspection.

Our inspection team

Our inspection team was led by:

Chair: Aiden Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust

Head of Hospitals: Nicholas Smith, Care Quality Commission (CQC)

Team Leaders: Sharron Haworth (mental health) and Julie Hughes (community health), Inspection Managers, CQC

The team that inspected community services for older people was comprised of a CQC inspection manager, two CQC inspectors and five specialist advisors which were a consultant psychiatrist, a junior doctor, a professor in the field of justice and health, a nurse manager, and a social work manager.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we held about this service and asked other organisations to share what they knew. We carried out announced visits on 31 May and 1 June 2016.

The inspection took place across a range of the community-based mental health services for older people. We sample community mental health services as part of our comprehensive inspection process. We therefore visited seven of the community older people's mental health teams. The teams we visited were:

- Stockport older people's community mental health team
- Stockport older people's intensive home treatment team
- Rochdale, Heywood and Middleton older people's community mental health team
- Rochdale, Heywood and Middleton older people's intensive home treatment team
- Bury older people's community mental health nursing team
- Tameside older people's community mental health team
- Tameside older people's intensive home treatment team

During this inspection;

- We spoke with 17 people who used the service and six carers.
- We received 14 comment cards from people who used the service.
- We spoke with the managers for each of the teams and two service managers.
- We spoke with 45 members of staff from a range of disciplines and roles. This included 19 members of staff who attended three focus groups held within the team offices. Staff we spoke with included doctors, nurses, psychologists, a speech and language therapist, occupational therapists and support workers.
- We looked at 33 care records.
- We looked at five Mental Health Act records relating to four patients on community treatment orders and one patient on a guardianship order.
- We attended two multidisciplinary team meetings and one handover meeting.
- We accompanied staff on eight home visits and observed how they provided care and treatment to people in their own home.
- We looked at the environments and equipment where the teams were based.
- We looked at the arrangements for the management of medicines.
- We looked at records about the management of the service including policies, minutes of meetings and results of audits.

What people who use the provider's services say

We spoke with 17 patients and six carers. Feedback we received from patients and their carers was extremely positive about the care they received by staff from the older people's community mental health teams. Patients told us they were treated with dignity, respect and kindness with staff showing a genuine interest in patients' wellbeing. Patients and carers told us that staff were responsive and knowledgeable. Patients felt that they received appropriate information about their condition, treatment options and other information including financial and future welfare decisions. Patients confirmed that they knew who to call if they were in crisis. Patients told us that staff understood their needs and respected their privacy and confidentiality. One patient told us the service had saved their life.

We did receive one negative comment from one carer who felt that the service did not keep them informed of their relative's ongoing care and treatment and felt that their relative was not receiving timely care and treatment. We signposted the carer to raise their concerns with managers in the service and then consider making a formal complaint.

As part of the inspection we left comment cards boxes at various locations across the trust for people to tell us their experiences. We received 14 comments from the locations where older people's community teams were based - nine comments about Rochdale's community older people's service and five comments about Tameside's community older people's service.

Summary of findings

These included 13 positive comments and one negative comment. The positive comments included patients and carers stating that staff were very helpful, friendly and caring. Patients felt they were treated with dignity and respect and always felt listened to, staff did their best to explain everything and patients and carers always felt they were kept up to date. Patients and carers also commented positively on the environment of the meeting rooms used by the teams.

The one negative comment was one person stating that there was a long waiting time between dementia diagnosis and a home visit to explain more about the condition and stated the reasons they thought this had occurred was possibly due to lack of staff.

Good practice

- There was significant service user involvement and community engagement including by people with dementia in Stockport. This included the work of Engage who were people with dementia providing peer support and post diagnostic support to people with dementia as well as being involved as partners in staff training.
- Service users and staff in Stockport were working in partnership with local leisure facilities to make them 'dementia friendly' including the local swimming pool and nearby theatre.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that patients' records are kept secure at all times, including ensuring secure storage of paper records when buildings are shared with staff who work alongside, but not for, the trust.
- The trust should ensure that patients on a community treatment order are informed about the availability of the independent mental health advocacy service.
- The trust should ensure that the appropriate legal certificate to provide treatment for mental disorder for community patients is kept with the medication card so staff and patients are assured that all medication administered for mental disorder to patients on a community treatment order was legally authorised.
- The trust should ensure that records contain full details of the legal safeguards when decisions were made on behalf of incapacitated patients such as recording the extent of any lasting or enduring power of attorney decisions, the conditions and the limits on any Deprivation of Liberty Safeguards authorisations that patients were subject to and whether patients had any advance decisions.
- The trust should ensure that staff request interpreter involvement based on patients' needs when their first language is not English and not just for significant appointments such as care programme approach reviews.

Pennine Care NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Stockport older people's community mental health team	Trust Headquarters
Stockport older people's intensive home treatment team	Trust Headquarters
Rochdale, Heywood and Middleton older people's community mental health team	Trust Headquarters
Rochdale, Heywood and Middleton older people's intensive home treatment team	Trust Headquarters
Bury older people's community mental health nursing team	Trust Headquarters
Tameside older people's community mental health team	Trust Headquarters
Tameside older people's intensive home treatment team	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- There were good systems in place to ensure that the Mental Health Act was being adhered to within the community older people's teams.

Detailed findings

- Mental Health Act administrators in the trust had systems and checklists to remind staff of their responsibilities including ensuring staff kept to key deadlines for patients on a community treatment order.
- Staff told could request an assessment under the Mental Health Act for older people in the community and this would generally be coordinated quickly with no reported delays.
- Records contained a full copy of the community treatment order, and showed that renewals occurred appropriately and the conditions of the community treatment order were monitored and met.

However:

- We found issues with patient rights and informing community patients about the independent mental health advocacy service on one patient's file. The second opinion appointed doctor certificate for one patient was not kept with the medication card. These issues were addressed during the inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

- People using the service of the community mental health teams for older adults were living in the community with a degree of autonomy and patients' capacity was assumed unless it was indicated otherwise.
- There was a record of mental capacity and consent when significant decisions were made.
- Staff supported patients to put legal frameworks in place while they still had capacity to help them plan for future decisions before they became more cognitively impaired.
- Some of the teams had undergone audits of their adherence to the Mental Capacity Act which showed areas of good practice.

- Staff had an understanding of their responsibilities in working within the Mental Capacity Act despite low uptake of formal training.

However:

- Records did not routinely record the extent of any legal framework for making decisions for patients such as relatives having lasting power of attorney.
- Staff within the teams provided professional support to patients in care homes and nursing homes. Staff did not routinely record the conditions placed on patients if they were under a Deprivation of Liberty Safeguards authorisation.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Staff within teams mostly provided care and treatment to patients in their own homes. If there were any concerns about staff safety, staff would see patients in pairs or arranged to see patients in safer alternative venues. In these cases, patients were offered interview rooms within the trust's hospitals (as most teams were located in offices next to inpatient wards). Rochdale, Stockport and Tameside teams were located within the hospitals close to the older people's inpatient wards. The Bury team had an outpatients department and team offices located in a building in central Bury.

Patients would also be asked occasionally to attend the team locations for various reasons including for memory assessment, to attend day hospital services or to see the consultant psychiatrist. The rooms used to see patients were clean with welcoming reception areas and well equipped interview rooms. Rooms were either equipped with alarm systems or staff wore personal alarms.

Teams had systems in place for visitors to sign in and out of the building.

Medication was not stored within team offices. Patients would receive their own medication from the GP and store it in their homes. The exception was a small amount of stock depot medication at Bury older people's community nursing team held in a cupboard. Depot medication was a special preparation of medication given by injection which slowly released into the body over a number of weeks. There was no medication stored in fridges. Medication was locked in a cabinet with access to the keys limited to senior nursing staff. There were checks on the temperature of the room where medication was stored to ensure that it was stored appropriately.

Safe staffing

The older people's community mental health teams each had a team manager and a number of community psychiatric nurses and support workers and then most teams had a range of social workers and allied health professionals working as part of the multidisciplinary teams. Some teams had higher staffing levels because they

covered a wider geographical area. For example Tameside older people's community mental health team employed 17.6 whole time equivalent nurses and four whole time equivalent support workers whilst Bury had 11 whole time equivalent nurses and 3.6 whole time equivalent support workers.

Actual staffing levels within teams were usually within the expected staffing levels with limited use of overtime and agency staff overall. There were no agency and bank staff used in the three months prior to our inspection. The teams with the highest staff vacancy rate was the Tameside older people's team with a vacancy rate of 16%, Tameside older peoples' home intervention team which had a vacancy rate of 11% and the Bury team which had a vacancy of 9%. Despite staffing levels being very slightly lower than the established levels in some teams, this did not impact on people waiting to be assessed or allocated to a named worker. Where there were vacancies, managers were working to address these with well-developed plans to recruit staff with people appointed into post but not yet started or interviews occurring in the near future.

There were low levels of sickness across most teams with five out of seven teams we inspected having sickness rates below 3.5%. The exceptions were Tameside older peoples' home intervention team with a sickness level of 15% and the Stockport older people's community mental health team with a sickness of 4%. We discussed the sickness levels with the team manager who explained that two members of staff were off long term sick. As the team was relatively small, any long term sickness disproportionately affected the sickness rates. If the staff sickness levels fell below a particular level, managers completed action plans to address this to ensure the operational efficiency of the service. Where there were three months of consecutive sickness absence above the trust target, this would result in this service being considered as one of concern and a hotspot area for greater scrutiny and support by senior managers.

Staff received mandatory training and were up-to-date as required. Mandatory training included moving and handling, conflict resolution, equality and diversity, basic life support, health and safety, infection control, adult and

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children's safeguarding, fire safety, information governance and prevent training which was training for staff to be aware of the need to prevent people from being drawn into terrorism.

The trust had a target rate of 95% for most of the mandatory training staff undertook. The initial data from the trust prior to the inspection showed that there was mandatory training uptake of 89%. The trust spreadsheet provided data on each team which was colour coded red, amber, green to show whether each teams uptake of training met these targets. This showed that most teams maintained good uptake of mandatory training compliance rates with many showing 95-100% compliance rates in many mandatory training courses at the end of May 2016. There were only a small number of shortfalls in mandatory training uptake levels. A small number of training courses for some teams were showing below 75% uptake rates. These were

- fire safety training in the Bury and Rochdale teams (33% and 50% uptake respectively),
- information governance in the Bury team (66% uptake),
- basic life support in the Stockport team (73% uptake),
- infection control in Stockport older people's teams (69% uptake) and
- conflict resolution training at Rochdale (55% uptake).

We discussed the training uptake levels with team managers and were assured that uptake rates had improved since this data and also where there were gaps, staff were booked on future courses to maintain and improve the uptake rates. We did not identify any critical deficits in staff understanding as a result of lower uptake in mandatory training levels.

Staff reported having manageable caseloads which enabled them to monitor patients to provide safe and effective care. For example, staff were managing a caseload of between 20-30 cases at any one time. Staff told us and records confirmed that caseloads were managed in supervision and reviewed regularly. Staff received regular supervision.

Managers and service managers received monthly reporting information which helped them to oversee the levels of activity within the team such as new referrals, appointments, open cases and quantitative data on whether the capacity of the team could meet the demands placed upon them.

Assessing and managing risk to patients and staff

Referrals were screened primarily by the single point of access worker or duty member of staff who would then assess the information on each person and determine if the person was accepted into the service for a more formal assessment.

Staff undertook comprehensive risk assessments at initial referral and updated them when necessary. Most of the risk assessments were kept up-to-date and were of a good standard to enable any staff member to understand the risks presented for each patient. On two out of 33 files, risk assessments had not been updated for some time. We brought these to the attention of the relevant managers.

Risks assessments were routinely reviewed every six months during a care programme approach review or sooner if there were significant changes in patients' risks. Patients we spoke with confirmed they knew who to contact in a crisis and their care plans were clear in relation to what to do in a crisis.

Patients' physical health was monitored and checked initially and on an ongoing basis. Staff ensured that patients had a comprehensive physical health check at least every six months as part of the care programme approach reviews. There was evidence of appropriate liaison with GPs and other health professionals where people had an identified health need that required monitoring.

Patients received regular checks to make sure that any medication they received was not causing adverse effects; especially when people were first put on medication such as Clozaril which requires regular blood checks. These checks included staff supporting patients to carry out formal checks such as the Liverpool University Neuroleptic Side Effect Rating Scale which was a self-rating scale for measuring the side-effect of antipsychotic medication.

Safeguarding matters were considered as part of the initial referral, assessment and on an ongoing basis through the risk assessments. Staff were trained in safeguarding matters and had a good understanding of how to raise a safeguarding alert. However, in many teams the social work input was not integrated and, where this was the case, staff informed us that they were not involved in the full safeguarding process because this was now passed to the local authority to investigate. We saw that staff had taken

Are services safe?

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appropriate action when they became aware of a significant safeguarding matter. For example we saw an example of an alert being made following suspected financial abuse of a vulnerable adult by a family member.

Lone working procedures were well established between the teams. All members of staff were provided with mobile phones and signed in and out of the buildings. The trust had a lone working policy in place. Staff were following this at each location we visited. Staff at each location signed out and ensured the service had information on their appointments.

Checks on staff whereabouts were carried out by a member of staff allocated including the duty worker or an administrative member of staff acting as a shift co-ordinator. If there were identified safety risks, or if the person was not known to the service, they would ensure two members of staff attended the appointment. Staff within the teams had a well-known specific phrase that could be texted or telephoned to alert colleagues if they were in danger.

There were good arrangements regarding safe medicines management. There were appropriate arrangements in place where medication was stored and to check and sign documents prior to stock depot medication being dispensed. There were appropriate checks on the stock levels. We sampled the stock levels and the stock levels and the records matched.

In Bury, patients were seen by dementia advisers from the Alzheimer's Society for ongoing post diagnostic support and staff from the Alzheimer's Society worked out of the same offices as the community mental health team staff. There were unlocked current and archived patient records within the secure staff areas in Bury. There were archived records in an unlocked cupboard and current patient notes were kept with medical secretaries in an unlocked area even though it was a shared building with dementia advisers, who were non-trust staff, working in the building.

While an information sharing protocol was in place between the trust and the Alzheimer's Society, this involved sharing information between the trust and the dementia advisers on a need to know basis. The unlocked patient records included health records for all the patients receiving services and not just those patients receiving support from dementia advisers. We were assured by the

trust that there had been no data breaches relating to information data or loss reported. We did not identify any concerns that non trust staff, including the dementia advisers were accessing information inappropriately.

The trust took action to address the security of the records immediately following the inspection so that records were locked and patient data was kept securely. This included sending out a briefing to all trust staff, a memo to staff in the Bury team, locking areas within the building, purchasing new lockable filing cabinets and a new more robust protocol to ensure that any requests for viewing health records were properly made and considered so that information was shared on a need to know basis.

Older people's community teams were included in the trust's business continuity management process which aimed at managing varied operational risks such as a significant event, fire, critical staffing issues or other major incident. Staff had access to a detailed document to guide them to ensure the continuity of service delivery following unexpected disruption to normal working.

Track record on safety

We looked at the incidents data reported by the trust. These included incidents of expected deaths of people receiving services from the older people's community mental health teams. When we analysed the data about the trust's incidents, there were no significant adverse events in relation to older people's community teams in the last 12 months. There had been no coroner's ruling about any aspects of the work of the community mental health teams for older people.

There was no other significant concerning information highlighted involving the community older people's services. This was corroborated by managers in the teams who confirmed that that there had not been any significant safety incidents recently and through the trust's which analysed incidents including medication errors, significant self harm, security incidents and serious incidents.

The Stockport services had hosted the coroner for a visit to show them what they did and how they worked to aid the coroner's understanding of the services available for inpatient and community mental health services. This helped foster better joint understanding when the coroners became involved in patients' care following a death.

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Reporting incidents and learning from when things go wrong

Staff knew how to raise safety incidents and the types of incidents to report. Incidents were inputted onto the trust's incident recording system. Staff were aware of the need to report the deaths of patients in receipt of community mental health services even when they had not had contact immediately prior to the patient's death.

There was varying information received back into the teams about the numbers of types of incidents. Some managers could clearly state the number and types of incidents. For example in Bury, the manager used a spreadsheet to understand the number of incidents which did include a significant number of expected deaths but also isolated incidents of missed depot injections and miscommunication when people transitioned between teams.

Incidents were discussed and addressed in team meetings. The trust produced a regular briefing newsletter to staff that summarised information across the trust in relation to incident investigations, complaints outcomes and other events where learning was identified. This briefing was discussed in team meetings and available in the staff office. This helped to ensure lessons were learnt across staff

groups and not just at the location where the incident originally occurred. Action from incidents and patient alerts were discussed in team meetings and at individual staff supervision to ensure lessons were learnt were properly disseminated.

Staff were aware of the need to say "sorry" if necessary, aimed to resolve problems at a local level and carry out an incident review if there had been actual or potential harm to the patient. We saw that one 'near miss' incident nearly led to a patient receiving two doses of depot medication due to communication issues between the community and inpatient wards whilst a person was on leave from hospital. This had been picked up so lessons were learnt and action put in place to prevent a reoccurrence. There had been no incidents that met the harm threshold identified in the duty of candour regulations within the older peoples' community mental health teams.

Staff received feedback and debriefing from incidents within the trust usually from their line manager. In Stockport, staff attended a reflective practice session led by psychology staff to help them work with more complex patients. Staff who attended coroner's inquests felt supported by their line managers and wider team members.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We looked at 33 care and treatment records of patients across the community mental health teams for older people. Patients had well documented assessments and care plans that described how their needs would be met. Assessments included both medical and nursing assessments including consideration of physical health problems that required treatment or further investigation. There were appropriate investigations to rule out a physical health cause when people were referred with confusion or suspected early stages of dementia. Teams worked with GP services as part of the shared care protocols to ensure people received relevant physical health checks.

Patients were receiving care under the framework of the care programme approach which meant that patients had a named worker, a care plan which outlined the care they would receive and had regular reviews of care. Care plans covered a range of needs including patients' medical needs (physical and mental health needs and medication), nursing interventions and social needs (accommodation, finance, employment and leisure needs). Patient needs and care were reviewed following each interaction and formally every six months at care programme approach review meetings. Care plans identified support to address the symptoms of mental disorders.

There were multiple patient recording systems including separate consultant psychiatrist records, paper records and electronic records. This made it difficult to find key documents and the risks of patient information being held across multiple records were not always fully mitigated. For example, the electronic running records did not always identify patients being seen by the consultant psychiatrist and this record was stored elsewhere. However, staff were able to locate information we asked for in a timely manner.

The team offices were located on site so the hospital ward staff and community teams were able to access records quickly when patients moved between teams. The only exception was the Bury team where records were held in the team offices in Central Bury about 1.5 miles away from the hospital site. Records were couriered between the two sites when required and a system was in place to track the record to avoid the risks of data going missing. If records were required out of hours from the Bury team offices,

there was a system in place to ensure ward staff could get these. The trust was in the process of rolling out a fully electronic recording system which would mitigate these issues.

Best practice in treatment and care

Staff within teams provided a range of treatments and ran a range of groups including nursing support, daily living assessments, support work input, and recovery groups. Patients on anti-psychotics and lithium were monitored to ensure that medication was at optimum levels. Clinicians and nurses were aware of best practice guidance and were putting this into practice for example ensuring there were clear rationales given for anti-psychotic prescribing for people with dementia. We saw that there were a small number of patients with functional mental health needs on high-dose anti-psychotics. Where this was the case, we saw clear reasons and, where appropriate, patients were on a reducing programme.

Talking therapies were also available. People received cognitive behavioural therapy and other therapies which were nurse led. Patients who required psychology input were referred to the psychology team with some teams having psychologists integrated within teams. Where psychology services were not integrated there was a short wait to receive psychological treatment.

The services followed a dementia pathway which was based on National Institute for Health and Care Excellence (NICE) guidance; this included memory assessment, diagnosis, post diagnostic support and shared care arrangements as part of the pathway. The services used a range of outcome measures which included Health of the Nation Outcome Scales.

There was evidence of clinical audit to ensure that care and treatment was benchmarked against best practice standards. For example, in Bury a project and audit had occurred to reduce anti-psychotic prescribing for people with dementia. This involved working with GPs and primary care services to ensure there was a dementia lead in each surgery. The audit for 2015 showed a reduction in anti-psychotic prescribing for people with dementia from 24% to 15% within the first year.

The range of disciplines ensured that patients could access appropriate assessments and professional guidance. For example the speech and language therapists provided swallowing assessments for people at risk of aspiration.

Are services effective?

Good 

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Staff worked with patients, relatives and carers to receive accurate information about patients' life stories which was then translated into a person centred care plan. This ensured staff provided care and treatment to patients with dementia which was individualised and respected patients' personhood in line with recognised research into providing quality dementia care.

Skilled staff to deliver care

Teams comprised staff from a range of mental health disciplines which included consultant psychiatrists, junior doctors, occupational therapists, and community psychiatric nurses, support workers and administration staff. Some teams also had psychologists, speech and language therapists and/or physiotherapists. Up until recently most teams had mental health social workers integrated within teams. However, within certain local authorities, social workers had moved out from the teams into dedicated social work teams. Staff reported that there continued to be good working relations and referral and that input from social workers had not been affected.

As well as mandatory training, staff were encouraged to attend training on delirium, personality disorder awareness, dementia and carer training, cognitive behavioural therapy (CBT) skills and cognitive stimulation therapy. Stockport older people's services had a dedicated education worker who provided specialist training to staff, patients and carers on various aspects of dementia care.

There was good uptake of managerial supervision in teams. Staff within teams did not have separate clinical supervision; management supervision included opportunities to reflect on their work, discussion about managing cases and handling difficult issues. Staff told us and supervision records confirmed that staff caseloads and performance were regularly discussed.

Figures showed that most staff within older people community mental health services had an annual individual personal development review in the last year. Six of the seven teams we visited had appraisal rates of over 90%, with the Bury team and the Tameside older people's home intervention teams with 100% appraisal rates. The Stockport community mental health older people's team had slightly less uptake of appraisal with five out of 21 staff not having an appraisal within 12 months prior to 31 May 2016 which equated to a rate of 76%. Staff confirmed that

they had received a review; felt supported and were aware of their own personal development goals. Staff were committed to providing high quality and responsive care to older people which met patients' needs.

Multidisciplinary and inter-agency team work

Staff within teams worked together to plan ongoing care and treatment in a timely way through the regular multidisciplinary meetings. Care was coordinated between teams and services from referral through to discharge or transition to another service. Multidisciplinary meetings were used to collaboratively manage referrals, risks, treatment and appropriate care pathways options.

The teams operated shared care arrangements with GPs and primary care services which outlined which part of the health system was picking up aspects of patient care. Post diagnostic support for people with dementia was provided by different agencies in different localities. For example in Bury this service was provided by the Alzheimer's Society. Once people with dementia received initial assessment, diagnosis and post diagnostic support, patients' care was frequently transferred back to the GP for ongoing monitoring. General practitioners could refer patients back to the community teams at any point if the needs of the patient changed.

Teams consisted of staff that carried out initial referral through the single point of access team or worker, community mental health team, memory assessment, intensive home treatment and more specialist roles such as early onset team in Stockport and vascular dementia worker in Bury. Staff liaised with representatives of the rapid assessment, interface and discharge teams to provide ongoing support in discharge from acute medical wards. Staff within teams had a shared understanding of each other's roles and were committed to working together to ensure patients' needs were met. This helped to ensure patients were moved through the health system and received care from the most appropriate team at any given time according to their needs including when they were in mental health crisis. Staff linked in with the inpatient services for people who had been admitted to hospital under a section or informally.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Overall we found good systems in place to ensure that the Mental Health Act was being adhered to within the community older people's teams. Mental Health Act

Are services effective?

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administrators in the trust had systems and checklists to remind staff of their responsibilities including ensuring staff kept to key deadlines for patients on a community treatment order.

Staff told us that they could request an assessment under the Mental Health Act for older people in the community and this would generally be coordinated quickly with no reported delays in getting professionals to coordinate and carry out the Mental Health Act assessment.

We saw the records relating to community treatment order for four patients. A community treatment order is an order used when patients were discharged from hospital to enable them to be recalled to hospital if they become unwell and also places conditions on patients whilst they are living in the community. Records showed that the community treatment order paperwork was in place, a full copy of the community treatment order paperwork was available, renewals occurred appropriately and the conditions were monitored and met. Patients' care plans reflected the conditions placed on them while on a community treatment order. Records showed that patients also had their community treatment order independently reviewed by the hospital managers and the mental health tribunal.

We found minor issues with patient rights and informing the community patient about the independent mental health advocacy service on one patient's file. While it was clear the person had been informed of their rights, it was not clear that following the renewal of the community treatment order, that they had their rights re-read. Records showed that staff were arranging an interpreter for this patient but there had been a delay in securing an interpreter for the patient's own language.

It was also not clear that patients on a community treatment order had been informed of their legal right to receive support from the independent mental health advocacy services.

The medication for mental disorder for patients subject to the community treatment order was appropriately authorised on an appropriate legal certificate. However, the legal certificate authorised by the second opinion appointed doctor was not routinely kept with the medication card for one patient. By placing the legal certificate with the medication card, staff and patients are

assured that all medication administered for mental disorder was legally authorised including when the depot anti-psychotic injection was given. This was addressed during the inspection.

Good practice in applying the Mental Capacity Act

People using the service of the community mental health teams for older adults were living in the community with a degree of autonomy and patients' capacity was assumed unless it was indicated otherwise. There was a record of mental capacity and consent, when significant decisions were made or when staff contributed to these discussions. For example, when people needed to go into hospital, being considered for longer term residential care placement, or if covert medication was being considered when patients were in residential care. Staff within teams contributed to best interest considerations where necessary.

Some records showed carers and representatives had lasting or enduring powers of attorney which was a legal framework for making decisions. However records did not routinely record the extent of the power of attorney, for example whether it covered health or welfare or financial decisions. Where staff recorded clinical information on paper records, records did not record that staff routinely checked or made further enquiries whether patients had an advance decision as part of their initial assessment process. Managers accepted the need to have details of advance decisions and the power of attorney so staff could work within them especially when significant decisions were being considered.

On a home visit we saw a staff member discussing lasting power of attorney with a patient with a new diagnosis of dementia. This showed that staff supported patients to put legal frameworks in place whilst they still had capacity to help them plan for future decisions before they became more cognitively impaired as a result of the progressive nature of their illness.

Mental Capacity Act training was not a mandatory requirement for staff. There was low uptake of Mental Capacity Act training. In one team, nine out of 14 staff had not received formal Mental Capacity Act training in the last five years. Nevertheless, staff had an understanding of their responsibilities in undertaking mental capacity assessments when they were the principal decision maker. Staff ensured health decisions were made based on mental capacity or in the best interest of the person.

Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

As part of the post diagnosis support for people with dementia, people received information. This included guidance on making decisions prior to the progressive nature of dementia, such as lasting power of attorney for health, welfare and financial decisions.

Some of the teams had undergone audits of their adherence to the Mental Capacity Act. For example audits recognised that the Rochdale Middleton and Heywood team showed areas of good practice including partnership working with Independent Mental Capacity Advocates (specialist advocates that support vulnerable adults that lack capacity without friends have someone to speak up on

their behalf when important decisions were made). The audit did identify some shortfalls including more robust capacity assessments and staff training not being up to date.

Staff within the teams provided professional support to patients in care homes and nursing homes. Some of these patients were under a Deprivation of Liberty Safeguards authorisation. Staff did not routinely record the conditions placed on patients as a result of the Deprivation of Liberty authorisation which meant that trust staff may not be fully aware of all of the conditions patients were under when trust staff provided input. We observed a professional visit for an assessment of a person in a care home; staff from the team advised the care home on the necessity for a Deprivation of Liberty Safeguards authorisation.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

Feedback we received from patients and their carers was extremely positive about the care they received by staff from the older people's community mental health teams. Patients told us they were treated with dignity, respect and kindness with staff showing a genuine interest in patients' wellbeing. Patients and carers told us that staff were responsive and knowledgeable. Patients felt that they received appropriate information about their condition, treatment options and other information including financial and future welfare decisions. Patients confirmed that they knew who to call if they were in crisis. One patient told us the service had saved their life because of the input they had received from staff within the community team.

Patients told us that staff understood their needs and respected their privacy and confidentiality. Records showed that staff went the extra mile to support patients. This was particularly apparent in Stockport, where support workers supported patients with all aspects of their lives. One record showed a support worker spending a significant amount of time ensuring a patient's boiler was repaired so the patient was not left too long without central heating.

We did receive comments from one carer who we spoke with over the telephone following the inspection. The carer felt that the service did not keep them informed of their relative's ongoing care and treatment. They told us that their relative lacked capacity to consent to the carer receiving information but felt it should be shared in the patient's best interests. They felt that their relative was not receiving timely care and treatment as there were delays in getting treatment, delays in organising basic packages of care and poor communication from the team. We signposted the carer to raise their concerns with managers in the service and then consider making a formal complaint if they continued to be dissatisfied with the care their relative received.

As part of the inspection we left comment cards boxes at various locations across the trust for people to tell us their experiences. We received 14 comments from the locations where older people's community teams were based. These included eight positive comments and one negative comment about Rochdale's community older people's service. The positive comments included patients and

carers stating that staff were very helpful and friendly, patients felt they were treated with dignity and respect and always felt listened to and the environment of the meeting rooms were safe and hygienic. The one negative comment was one person stating that there was a long waiting time between dementia diagnosis and home visit to explain more about the condition and stated the reasons they thought this had occurred was possibly due to lack of staff.

We also received five positive comments about Tameside's community older people's service. Comments included staff were very caring, do their best to explain everything and patients and carers always felt they were kept up to date. Patients and carers also commented on the good environment of the meeting rooms.

We observed positive interactions between staff and patients during home visits with people giving complimentary statements about the care they received. Staff showed warmth and an empathic engagement with patients and carers. Patients who were clearly distressed due to their dementia were treated calmly and sensitively by staff to reassure them and alleviate their anxieties.

We saw in some teams a number of compliments made by patients into the standard of care people received.

There were good results on the friends and family test with patients stating they were happy to recommend people they know to receive treatment from older people's mental health community teams. For community older people's teams, 85% of respondents in the last quarter of the financial year up to March 2016 said they were extremely likely to recommend the service to friends and family and a further 11% were likely to recommend the service.

We carry out an annual survey of community mental health patients by sending a questionnaire to a sample of patients receiving community mental health services in the trust which included people over 65. There were no significant issues of concern from the last survey in 2015 in relation to patients' experiences of community mental health services. The trust was performing about the same as most other trusts in most areas of questioning.

The involvement of people in the care they receive

People were involved and encouraged to be part of care and treatment decisions with support when it was needed. People told us that they felt involved and supported when they first received a diagnosis of dementia.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Patients were provided with copies of their care plans or it was recorded in the care records when a copy had been declined by the person, with an explanation. In 29 out of 33 records we saw a patient had been given or offered a copy of their care plan. In 4 of 33 records there was nothing to indicate whether patients had received a copy of or an explanation why their care plan could not be shared with them.

People with dementia and their carers were provided with information regarding benefits, driving, lasting power of attorney and advanced decisions.

There was significant service user involvement and community engagement, including by people with dementia, in Stockport. This was a service called Educate which was supported by the trust and facilitated by Stockport's dementia trainer. Their work included:

- Service users worked with people who had received a diagnosis of dementia, meeting for peer support.
- Service users and staff provided an eight week programme for staff and people with a diagnosis of dementia which included an overview of dementia, medication, legal aspects of having cognitive impairment including future planning and the importance of diet and exercise.

- Service users were involved in the initial and ongoing training of staff and student nurses.
- Service users and staff worked as partners in working with local businesses to make them 'dementia friendly' (for example, by working with the local leisure centre and nearby theatre so staff working there became more aware of the needs of people with dementia).

Patients were informed of the Educate programme by staff. Patients we spoke with during and following the inspection spoke very positively about the Educate programme and how it helped them.

Patients were also working as volunteers in the hospital based cafes in Stockport and Tameside.

Staff helped patients and carers to cope emotionally with their care and treatment. Carers were informed of their right to an assessment of their needs. Patients were supported to maintain and develop their relationships with those close to them, their social networks and communities. For example, the vascular dementia worker had set up a range of community groups such as walking groups in Bury and the educate group in Stockport met regularly for social and reading groups.

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

The teams had clear age ranges, eligibility and exclusion criteria that set out who they would work with and where people should be signposted to if they did not fall within the eligibility criteria.

The older people's community mental health teams accepted referrals from inpatient wards, other trust services and via local GPs. All new referrals came through the single point of access worker or duty worker. Staff then reviewed each new referral based upon the information they received, assessed the information and decided what action to take. There was no standardised referral form for referral into the older people's teams.

The single point of access or duty worker would coordinate a visit or assessment quickly if a person needed this. People were contacted by telephone and an appointment was offered as soon as possible. The initial assessment evaluated people's needs and the care and treatment options available to them. People and staff we spoke with confirmed that there was rapid access to a psychiatrist when required. Calls were answered promptly during our visit.

The teams had a target of assessing patients within six weeks from the date of the initial referral and ensuring people received a diagnosis within 12 weeks from the date of the initial referral. Teams were meeting these targets. There were no waiting lists to receive an assessment or receive treatment.

The teams operated a 9am to 5pm service seven days a week with more limited staff at weekends. At night, people could contact the emergency duty team within social services or attend the acute hospital emergency department to see a staff member from the older people's rapid assessment, interface and discharge team who were based at the hospital. If people were in crisis, they were triaged to see whether they required a Mental Health Act assessment.

People who used services told us they had not experienced delays or any cancelled groups or appointments. Teams could respond promptly if there was a sudden deterioration in a person's physical or mental health. Staff attempted to engage people who missed appointments, mainly by phone calls and letters and discharged them if

they no longer accessed the service following several failed calls. The police could also be called to do a welfare check when there had been no contact from a patient for a number of weeks or a number of failed attempts to contact patients.

Most teams had home intervention team within the team. Staff within the home intervention teams focused on assisting patients to remain within the community and avoid admission to hospital where possible. The exception was the team in Bury where all members of the team also carried out the home intervention function.

All the teams had developed links with the acute wards to make sure that patients were admitted to and discharged from hospital when clinically appropriate. Patients were usually able to access a bed within their own locality when an inpatient admission was needed. On occasions, patients were admitted and treated in a different part of the trust with a bed in one of the neighbouring localities located first and then further afield if necessary.

Staff within the home intervention teams were the gatekeepers for inpatient beds during their hours of operation. The percentage of patients' admissions which were gate kept by the home intervention teams across the trust was above the England average for 11 of the 12 quarters reported. In the north division (Rochdale, Bury and Oldham), staff were assisted by a bed manager who helped to secure an appropriate bed for patients requiring admission. This meant that patient admissions were assessed to ensure that only those patients that require an inpatient bed were admitted to hospital.

Staff within the home intervention teams also facilitated the early discharge of some patients from hospital by offering them intensive support during the transition from hospital to the community to reduce the risk of them relapsing. The home intervention teams had regular contact with the inpatient wards to identify patients who may be appropriate for early discharge with support from the team. This included providing support to patients during leave periods from the ward. Relations between staff within the inpatient areas and staff within community teams was good across the trust. Aftercare support was agreed and people were followed up on discharge from hospital.

People discharged to care and nursing homes continued to receive support from staff within the community mental

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

health teams. This included staff from the older people's community mental health teams providing specialist support, advice and training to staff working in the care homes to help them better meet the needs of people in their care.

Patients were also signposted to appropriate services in their locality to provide ongoing post diagnostic support after a diagnosis of dementia. For example in Bury, patients were seen by staff from the Alzheimer's Society for ongoing post diagnostic support. In Stockport, there was a user led post diagnostic support group called Educate.

Shared care protocols were in place with primary care services. This ensured that people under the care of the community mental health teams were properly treated and monitored in the community. People with dementia would be transferred back to primary care once they had received a diagnosis and initial treatment and would not remain open to the team. People with functional mental health needs, such as depression or schizophrenia, who had been stable for many years, were also transferred to primary care. The impact of this was that staff had manageable caseloads because they were working with only those patients who required ongoing secondary mental health care services. If patients' conditions worsened then they could be quickly referred back into secondary mental health services.

The facilities promote recovery, comfort, dignity and confidentiality

Staff provided a range of flexible support to patients dependent on their needs. This included face to face visits to patients in their own homes at a time that suited them as well as telephone contact.

We observed staff providing care to patients in their own homes. Staff treated patients with dignity and respect on all the interactions we saw. During handovers, staff talked respectfully about the patients in their care.

At the locations where the community older people's teams were based, the waiting areas and interview rooms were welcoming and comfortable.

There was a good range of information leaflets in the waiting areas including information on the trust's services, diagnosis and treatment information, information on community and voluntary groups in each locality and practical matters on common issues faced by patients such

as welfare benefits, managing finances and the legal framework for future decision making. Staff within the teams also had information leaflets available to take on home visits for patients and carers.

There were systems in place to request patients' consent to pass information on to relatives so that patients' permission was properly obtained before key details or updates were passed on.

Patients were informed about the options for funding their care packages to gain control of their care through self-directed support which allows a person to purchase or arrange their own care to meet agreed health and social care outcomes.

Meeting the needs of all people who use the service

Teams had developed their services according to local need. For example, Stockport had an early onset dementia team within the range of community mental health services for older people. This helped to assess, support and treat patients who were under 65 with a diagnosis of dementia. In Bury, the service had a designated worker to provide ongoing support to patients with a diagnosis of vascular dementia. Vascular dementia is a form of dementia which occurs when the brain is damaged because of problems with the supply of blood to the brain.

At the locations where the community older people's teams were based, the waiting areas and interview rooms were accessible to people with limited mobility and patients who use wheelchairs. In each of the buildings where the teams were based, there was a toilet accessible to patients with disabilities.

The trust provided services to communities with diverse ethnic backgrounds. For example Rochdale, Bury and Oldham had large south Asian populations and there was a large Jewish community in south Bury. Staff could access interpreting services which provided face to face and telephone interpreting services. Staff had a good understanding of the needs of their local communities. There was proactive contact with Black and minority ethnic communities to promote the work of the teams, improve referrals and for health promotion. For example, the Bury team had held events reaching out to south Asian and Jewish communities.

We were given examples by staff where interpreters had been accessed to support patients whose first language

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

was not English. However, in Bury whilst interpreters were arranged for significant appointments such as care programme approach reviews when patients first language was not English, staff in the Bury team did not always request interpreter involvement for more routine appointments. The trust literature could be translated into different languages on request.

Records and observation of meetings showed that patient's individual, cultural and religious beliefs were taken into account and respected.

Listening to and learning from concerns and complaints

There were 16 formal complaints received by the trust regarding mental health community services for older people from April 2015 to May 2016. The complaints related to ten mental health community teams for older people including rapid assessment, interface and discharge teams for older people. Seven teams had received one complaint each; three teams had received three complaints. These were the memory assessment and treatment service in Oldham, the older person's east team in Oldham and the rapid assessment, interface and discharge teams for older people in Stockport.

Of the 16 formal complaints, two complaint investigations were still ongoing at the time of the inspection. Of those that had been investigated none of the complaints had been fully upheld and two complaints had been partially upheld. There were no significant issues or repeating

themes from the summary information about the 16 formal complaints regarding mental health community services for older people. Therefore the teams did not receive many complaints and where complaints had been raised, we saw that the trust had worked to investigate and resolve these.

During the twelve months prior to the inspection, the trust also received 36 compliments about the older people's community mental health teams.

Patients and carers told us they knew how to complain about the community services for older people and felt confident that their complaint would be treated seriously. When we spoke with patients and relatives for this inspection, we only received one negative comment from one carer who felt that the service did not keep them informed of their relatives' ongoing care and treatment and felt that their relative was not receiving timely care and treatment. We encouraged the carer to raise their concerns with managers in the service and then consider making a formal complaint.

We saw posters in the reception areas of the team bases about how to offer suggestions or compliments and make complaints about any aspect of care and treatment. The trust had easy read leaflets on how to complain and the support available from the patient advice and liaison services in raising complaints informally or formally. There was also information on the trust's website on how to raise a complaint.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

The trust had the following vision.

“Our vision is to deliver the best care to patients, people and families in our local communities by working effectively with partners, to help people to live well.”

The following strategic goals:

- Put local people and communities first
- Provide high quality, whole person care
- Deliver safe and sustainable services
- Be a valued partner
- Be a great place to work.

When we spoke with staff on the older people’s community teams they showed professional commitment to providing high quality care in line with the trust’s values.

The older people’s teams had operational protocols which set out their aims and values. For example, the Tameside older people’s community mental health team’s operational policy stated that the team was “committed to providing person-centred care based on the psychologically minded recovery and enablement models. Clients will be treated with dignity and respect by staff who will work in collaboration with them and their carers. Each individual will receive the highest standard of care, provided by a team who are committed to the implementation of best practice.”

The trust had three quality priorities for 2015/16 which were:

- Sign up for Safety – Patient Safety
- Suicide Prevention – Patient Experience
- Admission Avoidance – Clinical Effectiveness.

Whilst it was clear that staff were committed to patient safety, suicide prevention and avoiding admission, these priorities were not visible within staff offices and there were no distinct projects occurring within older people’s community mental health teams to specifically develop

practice against these quality priorities. Senior managers in the trust did not provide any steer or guidance around how each team could evidence or develop services in line with the three quality priorities for 2015/16.

The trust was signed up as a key agency in the Greater Manchester health and social care devolution agenda which aimed to devolve more decisions and funding to services in the Greater Manchester area. As part of this dementia was identified as an early implementation priority. This led to a key project called Dementia United which involved various partners across Greater Manchester aiming to improve the lived experiences of people with dementia, and reduce pressure on the health and social care system. Dementia United had the high level aim to make Greater Manchester the best place in the world to live for people with dementia. The trust was involved in this work and the projects of Dementia United were discussed at the locality dementia strategic group meeting which the trust attended as a key partner.

Good governance

We found the older people’s community teams were well managed. There was a team manager in each of the community teams with Stockport having two team leaders due to the size of the teams based there. The team managers reported to a service manager in each locality who oversaw both inpatient and older people’s community service. Staff had clear roles and understood the reporting and management structure that was in place.

Team managers carried out caseload supervision and local audits such as care planning and care records audits. Managers had good clinical oversight and were aware of the pressures on the service. Staff mostly reported they had been appraised and supervised by their immediate line managers and felt supported to carry out their work duties by managers and their peers.

There were good governance arrangements in place including locality based service managers who supported teams.

The trust had a good governance structure in place to oversee the running of the older adult community mental health services. There were reports provided to service and team managers which provided monthly oversight of staffing issues, incidents, complaints, caseloads, average

Are services well-led?

Good 

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wait from referral to first contact, number of referrals, open cases and other key information so that services could be monitored and actioned taken to address any concerning information within the reports.

Managers reported into governance meetings monthly. Effective managerial operations meetings took place where incidents were discussed, team performance was reviewed and staffing and sickness in teams was considered, as well as standing items which included health and safety arrangements, risk management, data performance and quality, infection control measures, physical health promotion and adherence to the Mental Capacity and Mental Health Acts.

Leadership, morale and staff engagement

Staff told us that they felt supported by their immediate line manager and more senior managers.

Staff we spoke with in the older people's community mental health teams reported that their morale was good. Staff showed a commitment to providing quality care which responded to patients' needs. Staff felt able to raise concerns and were aware of the trust whistleblowing policy.

Team leaders felt well supported and were complimentary about the support they received from the service manager.

Staff had access to reflective practice sessions. Teams were well-led by committed managers.

Senior nurses felt that the service quality assurance could provide better integration and communication with allied health professionals from the trust's community health teams (such as physiotherapists and speech and language therapists) because there were not formally established links and liaison between these services to fully benefit from the advantages of being a combined community health and mental health trust.

Commitment to quality improvement and innovation

There was a commitment to service improvement and extending services to meet the needs of different patient

groups. For example development of the early onset team in Stockport as well as the rapid access, interface and discharge team to work between the acute medical wards and the community mental health teams. In Bury there was a vascular dementia specialist worker to better meet the needs of patients with this diagnosis. Staff in Bury were also engaged in the development of a new older people's community rapid access, interface and discharge team to work with and alongside primary care services.

These initiatives followed local dementia strategies and local commissioner intentions. This led to variation of service across the trust's footprint due to funding arrangements and commissioner intentions. Whilst there was no strategic plan currently in place to address these discrepancies to ensure equity of service provision based on local need, there was scoping work occurring to develop a trust wide older peoples strategy which included looking at the functional and organic mental health services, physical health co-morbidities, rehabilitation services for older people, inpatient services, improved services for managing challenging behaviour and working in partnership with social care, third sector organisation and carers.

Staff were committed to working with third sector organisations to provide part of the pathways for people with a diagnosis of dementia. For example in Bury, staff from the Alzheimer's society were providing post diagnostic support once people had received memory assessment and a diagnosis of dementia. In Stockport, staff from the team worked with a service user led organisation called Educate which provided support on an ongoing basis as well as peer support, social engagement and community involvement and education projects to promote dementia awareness. Managers contributed to the local dementia strategy in each area.

The trust's community mental health teams, rapid access, intervention and discharge teams or the memory assessment services were not accredited with the Royal College of Psychiatrists and there were no immediate plans to become accredited.